Bi-State Primary Care Association

Julie Wasserman
Department of Vermont Health Access
312 Hurricane Lane, Williston, VT 05495

Dear Ms. Wasserman and Department of Vermont Health Access,

On behalf of Bi-state Primary Care Association I have included below our public comments on the Dual Eligible Proposal.

Bi-State is a private nonprofit organization with a broad membership of thirty-two organizations that provide and/or support community-based primary care services. A 'voice' for the medically underserved, Bi-State members include Community Health Centers, Rural Health Clinics, private and hospital-supported primary care practices, Community Action Program, health care for the homeless programs, Area Health Education Centers, clinics for the uninsured, and social service agencies. Bi-State works with federal, state and regional health policy organizations and policymakers, foundations and payers to develop strategies, policies and programs that promote and sustain community-based, primary health care services. The mission of Bi-State is to foster the delivery of primary and preventive health services to the people of Vermont and New Hampshire with special emphasis on the medically underserved.

Proposed Public Comments on the Duals Project from Bi-State Primary Care Association:

1. Page 10, **Provider options to form a CCP or ISP:** "Provider options include such entities as Vermont's Designated Agencies for developmental and mental health services, Home Health Agencies, Area Agencies on Aging, Traumatic Brain Injury providers, the Vermont Chronic Care Initiative (VCCI), Support and Services at Home (SASH), and Specialized Service Agencies (SSA)." We suggest the list of providers to include primary care physicians and/or a network of primary care physicians in addition to the current entities.
2. Page 36, **Overall Implementation:** "On September 1, 2012, the MCE will issue a Request for Information (RFI) to identify one or more existing Vermont entities in each geographic area of the state with the interest and demonstrated capacity to become a CCP or ISP for one or more dual eligible populations." We propose an option to contract on a statewide basis in addition to the option to become a CCP or ISP in each geographic area of the state.
3. Page 24 **Payment Reimbursement Changes:** "The current model contemplates a combination of two funding mechanisms for each ISP: 1) a bundled payment for a defined set of services (including care planning, care coordination and home and community-based services); and 2) incentive payments for performance. The State will bear the risk for all other services (e.g., inpatient hospital, outpatient hospital, nursing facility, pharmacy)." We propose a consideration of a shared savings model to the providers (CCPs and ISPs) in addition to State and Federal shared savings proposed in the draft.
4. Page 36, **Timeline for responses from participants:** "On September 1, 2012, the MCE will issue a Request for Information (RFI) to identify one or more existing Vermont entities in each geographic area of the state with the interest and demonstrated capacity to become a CCP or ISP for one or more dual eligible populations. The MCE will select entities with which to pursue contractual agreements no later than October 31, 2012, and will develop contacts with these entities no later than January 31, 2013." We request the timeline for responses be extended to 60 days to allow more time for collaboration and communication with potential partners.
5. We propose the application of care management to medical as well as behavioral health. This could take the shape of a network of primary care provider care managers located at the site of

care as an additional option to a regional state employee. This would allow for the option of a care manager to be an employee of a primary care provider.

Please let me know if you have any additional comments or questions.

Susan J. Barrett, J.D.
Director Vermont Public Policy
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Cathedral Square Corporation

April 27, 2012

Mark Larson, Commissioner
Department of Vermont Health Access
312 Hurricane Lane
Williston, Vermont 05495

RE: Vermont's Demonstration Grant to Integrate Care for Dual Eligible Individuals

Dear Mark:

Thank you for the opportunity to comment on Vermont's Demonstration Grant to Integrate Care for Dual Eligible Individuals. We greatly appreciate all your work and the work of your team to prepare this proposal.

Cathedral Square Corporation entered into a Memorandum of Understanding with the Vermont Department of Health Access (DVHA) to administer the Support And Services at Home (SASH) initiative. It is in this capacity, as a partner with DVHA, that we comment on the draft proposal.

We write to wholeheartedly support the spirit and philosophy of the proposal. SASH was designed with and for – Vermonters who need comprehensive, effective and coordinated person-directed care that spans the medical, mental health and long term care domains. We aim to break down silos, including the silo of residential providers. "Independent living settings", whether congregate or single family homes, are increasingly the setting for post-acute care and can be better utilized to promote community based preventive care.

We applaud the Vermont Assembly of Home Health Agencies (VAHHA) for voting to pursue the formation of a statewide Integrated Service Provider with SASH. Representatives of the SASH Designated Regional Housing Organizations recently met with VAHHA to discuss how we will insure that all SASH partners - the Area Agencies on Aging and the designated Community Mental Health Agencies – can be at the table from the start as we design the ISP.

We support your focus on:

- **Enhanced care coordination with a single point of contact**: SASH participants retain their case manager, but have the added support of a community based care manager who supports both the client and the case manager by extending the support of the case manager beyond what is often limited to 2 hours/month;
- **Integration with the Blueprint**: SASH is part of the Blueprint for Health. These collaboratives are formally connected to the medical homes and Community Health Teams in each region enabling referrals between the primary care provider, the CHT and its extenders (SASH and VCCI);
- **Individual assessments resulting in comprehensive person-directed care plans:** SASH has designed one uniform assessment tool built on the state's Independent Living Assessment (ILA), plus evaluations of depression, cognitive, and nutritional status. We utilize the person centered

planning tools developed by Patti Cotton to insure that the Healthy Living Plans are developed by and with the person;

- **Support during care transitions**: Hospitals agree to a discharge protocol as a party to the SASH Memorandum of Understanding. In addition these protocols are adapted to nursing homes in the area. SASH has encouraged participation of nursing homes on the SASH regional advisory groups;
- **A single integrated pharmacy benefit plan**: Medication management by Wellness Nurses is a core (yet underfunded) function of SASH and has proven to result in avoidance of adverse medication events, improved adherence, and avoidable hospitalizations;
- **Payment reform connected to performance measures**: SASH provides a Medicare funded capitated payment to support care management and wellness nursing. The payment was calculated in part based on a business case model projecting cost reductions/increases in ten cost centers;
- **Improve sharing of health records, assessments and information**: SASH is scheduled to begin entering assessments and clinical activity into the state's Central Clinical Registry next week. This will enable timely access to information by all members of the SASH team: the VNA nurse, AAA case manager, or mental health clinician in the field. It will also enable analysis of health trends and measurement of outcomes;
- **Integrated Service Providers**: SASH is just that - a statewide network of regionally tailored collaborations among home and community based providers. Each collaborative includes the region's hospital, Visiting Nurse Association, Area Agency on Aging, one or more nonprofit housing providers, and PACE where it exists. Most collaboratives include the designated mental health agency and a couple of collaboratives include funders and academic institutions.

We suggest the following revisions to the proposal:

(1) **PAGE 9** We suggest this addition to the Core Care Model elements:
   a. **"A population based public health approach to prevention and evidence based programs**. The single largest determinant of health is behavior. All dually eligible Vermonters will have access to prevention and intervention programs that will reduce adverse health outcomes and costs over the long term. "

(2) **PAGE 10** We strongly support the Integrated Service Provider concept and hope to form an ISP with the existing SASH partners. We understand that ISPs will be risk bearing but will not be gatekeepers. We also understand that the state will bear the risk for inpatient, outpatient, nursing facilities and pharmacy. What would be helpful is further detail in this section on how the ISP can reduce volume and duplication of services if hospitals, SNFs and pharmacy are not part of the ISP.

(3) **PAGE 13** We appreciate the inclusion of SASH in the proposal and the recognition that SASH has embedded the application of evidence based practices throughout our work. We are proud of the comprehensive Directory of Evidence Based practices we have developed with the assistance of UVM College of Medicine Geriatric Fellows. However, we were disappointed to see DVHA characterize SASH as "a silo approach". To the contrary, one of our greatest accomplishments has been to bring together teams that cross home and community based agencies and hospitals on a regional basis. We would request the following revision on page 13: "The above existing evidence-based practices will be core elements of this Demonstration care model. However, with the exception of SASH, they are provided in a silo approach, focusing on a specific population or on specific needs…… In addition, due to the separate benefits covered by Medicaid and

Medicare, most of these individuals receive fragmented care with little or no coordination between their medical, mental health, developmental and support needs and services. SASH has addressed that fragmentation by linking primary care, acute care and home and community based services.

(4) **PAGE 19** The heart of SASH is the cross agency team. We suggest the following addition: "The key to SASH is that it is a cross agency team that include the nonprofit agencies the state has designated as case managers including home health, Area Agencies on Aging, PACE, community mental health, and nonprofit residential providers that have formal agreements with hospitals and primary care as part of the Blueprint."

(5) **TIMELINE**

a. We are committed to investing considerable time to forming an ISP with the SASH partners. Given the short term frame and complex reimbursement issues, we ask that the timeline include a mechanism for providing support from the DVHA consultants to any group working to form a CCP or ISP.

b. By January 1 2014 when the Duals program begins, SASH will have 6,120 Medicare participants, plus any non-Medicare participants we can fund through alternative sources (such as HASS, ROSS grants, housing budgets etc). We want to assure that there is a transition plan for SASH participants so that they do not need to leave the SASH program and/or opt out of the Duals program in order to remain in SASH. While SASH is voluntary, we want to insure that Vermonters who wish to remain in SASH can do so seamlessly given that SASH meets all of the Dual's Core Care Model elements.

Thank you very much. We look forward to working with you on implementation to serve Vermonters who are dually eligible for Medicaid and Medicare.

Sincerely,

Nancy Rockett Eldridge
On behalf of the Cathedral Square Board of Directors' Futures Committee:
Sharon Moffatt, RN BSN MSN, Board President
Marvin Klikunas, M.D., Board Vice President
Charlie Smith, Board Secretary
Paul Van de Graaf, Esq.

COVE

April 30, 2012

Julie Wasserman
DVHA
312 Hurricane Lane
Williston, VT 05495

Re: Vermont's Demonstration Grant to Integrate Care for Dual Eligible Individuals
Proposal to the Center for Medicare and Medicaid Innovation

Dear Julie:

On behalf of the Community of Vermont Elders and the Senior Citizens Law Project of Vermont Legal Aid, I submit the following comments on Vermont's dual eligible proposal. We generally support the proposal and believe that integrating Medicare and Medicaid benefits has the potential to improve the overall care provided to Vermont's seniors. We support the intent of the proposal which is to eliminate the barriers and obstacles that exist between Medicaid and Medicare in order to deliver integrate and coordinated care centered on the individual needs of the beneficiary.

A unique aspect of Vermont's proposal is having DVHA operate as a Medicare Managed Care Entity and to combine that with DVHA's role in operating Medicaid managed care. This financing model requires a leap of faith for Vermont's seniors and for the advocacy community as DVHA assumes responsibility for the Medicare benefit. However, we believe the proposed financing model, with DVHA as the Managed Care Entity, is significantly better than the alternative model that would have utilized commercial health insurance providers to manage the Medicaid benefit. As advocates for Vermont's seniors, we would have been extremely concerned about any proposal to privatize Vermont's Medicaid benefit, particularly in light of the unique complexity of Vermont's Home and Community Based Waiver program, Choices for Care.

The primary focus of the draft proposal is on the financing mechanism. Therefore it is difficult to fully understand how this proposal will impact beneficiaries and how this may change the benefits they receive and the care that is available and provided to them. We appreciate the Department's openness to beneficiary input on the design of the proposal, and on the level of public comment and discussion during the stakeholder process. However, the true impact on beneficiaries will be uncertain until the details regarding implementation are worked out over the next year. We hope that DVHA will remain committed to the core principles set out in the proposal and to continuing the process for extensive community input on the proposal for implementation. In addition to these general comments on the overall process, we submit the following specific comments and concerns.

Beneficiary Protections -The proposal contains a list of beneficiary protections that are provided for in the authorizing legislation, H.559. We worked with the Department to develop those protections and support having them incorporated into the proposal. However, there are additional protections that should also be specified in the proposal.

- Choice of providers. The proposal only specifically talks about choice of the primary care clinician. Beneficiaries should also be assured the full choice of providers, and the choice of an ISP.
- Reinvestment of 50% of the savings. The purpose of the proposal is to expand care options for duals, and this will only be achieved if savings are reinvested.
- Integrated appeals process. DVHA is working with advocates from Vermont Legal Aid to develop an integrated appeals process for beneficiaries. The appeals process needs to ensure that beneficiaries have the same level of protection and rights as they do now, while at the same time reconcile the different process for appeals in Medicaid and Medicare. One important aspect is an independent assessment for the beneficiary, and we appreciate that being included in the proposal.
- Independent advocacy system. This concept is included in the proposal, and we strongly support that, but the proposal does not provide for a specific funding mechanism or an assurance that adequate funding will be provided.

Eligibility Processing

The proposal is not intended to change eligibility standards. But it remains unclear how the proposal will impact the process or responsibility for eligibility processing and determinations. DVHA is described as the "locus of accountability" for all Medicaid services, and as being "responsible for all eligibility determinations". The proposal does not explain if eligibility for the "specialized programs", including Choices for Care, is changing or how application processing will be handled or who will have responsibility for clinical eligibility determinations.

Any such changes could be considerable for beneficiaries. Under the current scheme for CFC, DAIL determines clinical eligibility and DCF determines financial eligibility. Although this process may continue under the Dual proposal, DAIL's role in the proposal needs to be further clarified, and the complex intersection with the Medicaid's long term care financial eligibility rules needs to be explained. Our understanding of the proposal is that once eligibility is determined, the beneficiaries' care plan is then determined separately by their ISP according to their individual need based on an assessment. We support that concept. But this means that there would no longer be a utilization review process by DAIL, in which the beneficiary's approved care plan would be administratively capped by DAIL as part of the application or annual redetermination process.

Also, by combining the "specialized programs" into one combined Duals project, we hope that the "silo" approach to delivering care to seniors and other dual eligibles can be eliminated. One example is that

seniors in the program should have access to a full range of mental health services according to their needs, including the range of services that are currently only offered to those that qualify for the existing CRT program. Similarly, seniors diagnosed with major mental illness should have access to the full range of services offered by CFC, without regard to PASARR screening.

Managed Care Concerns

Under the proposal, ISPs will assume the risk and take management responsibility for the care provided to beneficiaries. It is unclear how the financial model will operate, or if there will be levels of payments to the ISP, similar to Medicare's case mix formula. However structured, a model that shifts the risk to the ISP creates a financial incentive for the ISP to limit the care provided to the beneficiary. Implementation of the proposal should be designed to minimize the incentive to cut care. DVHA should adopt clear mechanisms for oversight and monitoring of the ISPs to ensure quality and the adequacy of services. In addition to DVHA's responsibilities, this is a central reason why an independent advocacy system is so important, including the opportunity to seek an independent assessment as part of the appeals process. Beneficiaries must be informed of their rights to adequate care and their right to appeal the level of services offered or provided by their ISP. Given that most beneficiaries will have significant disabilities, they will need assistance to understand these rights and to pursue these appeals.

Thank you for this opportunity to comment.

Sincerely,

Michael Benvenuto

Project Director

cc: Gini Milkey, Executive Director, COVE
Michael Sirotkin, COVE

David Levingston, MA, LMFT

April 17, 2012

I am writing as a provider of mental health services.

I'm not sure if my comments are related to the discussion that folks were invited to participate in, but here they are:

As a Licensed Marriage Family Therapist, I **can** meet with folks who have the **Medicaid** plan, but I **can not** participate as a provider with **Medicare**. Psychologists can participate, as well as Licensed Social Workers, but not LMFTs.

Right now, if someone has both forms of coverage, I submit my claims for services rendered to VT Medicaid and they are processed without a hitch.
There are no problems. I don't have to do anything different. It's great.

So, I am writing to request that things continue as they currently are for providers with my license.

The reason why I am writing to share this info is to alert you to the fact that it isn't always so easy with some managed care organizations (MCOs). Because of this Medicaid/Medicare issue, some MCOs require other actions to be taken in order to process claims. In the past, some of them wanted providers to submit claims directly to Medicare, and then the provider would have to wait for a denial of service letter to be sent back, and then submit that denial letter along with a claim to the members Insurance plan. The problem is that Medicare is no longer sending out those denial letters, so a new arrangement is needed. With VT Medicaid, there is a system in place that seems to take this into consideration, and claims are processed just like any other claims for folks who don't have dual coverage.

I also want you to know that I have appreciated the experience I have had with customer service over the years. I have received timely and clear answers to my questions, and the human interaction has been pleasant. It makes a difference and is valued by me.

Thanks for your consideration.
David Levingston, MA, LMFT
Phone: (415) 717-0918
Office: 139 Main Street, Suite 404, Brattleboro, VT 05301

Dion Lashay

Comments on Vermont's Proposal for Serving Individuals who are Dually Eligible (for Medicaid and Medicare)

General Response
Dion noticed that the application itself is very provider focused and does not include a lot of the ideas and discussion of the stakeholder meetings. This is probably because of the required format and page limits. Is there a way to highlight some of the key discussions and recommendations about supporting person directed choices? Will these be used during project implementation if the project is funded?

He suggests including the Finch Network focus group report in an appendix if that is allowed, to fully present the issues, recommendations and concerns of dually eligible individuals.

Dion feels strongly that Vermont needs to integrate disability coverage issues into our health care reform. He is pleased that this project supports this kind of integration and hopes we see it for the broader population of individuals with disabilities. The result should be that individuals with disabilities are not forced to access services through multiple plans and government programs but can have a more integrated access, one card. He supports use of an "opt out" option for those who want to stay in existing programs. He would like to see improvements to existing systems of services, including the system of care planning system for individuals with developmental disabilities. He said that the
current system of care for individuals with developmental disabilities uses an unfair diagnostic profile to approve or deny access to funded services. People can be clinically eligible but be denied funded services. He notes that this process is discriminatory and paralyzes many individuals who are not eligible for assistance but have an equal need for services and supports. Dion hopes that health care reform will stimulate needed improvement in access and quality of developmental and mental health services.

CCPs and ISPs
Dion prefers the Integrated Service Provider (ISP) model as a way to support more integrated person centered services. However, if providers are not initially able to implement an ISP approach, he suggests that a timeline and plan be developed with participating Care Coordination Providers (CCPs) that help them move to an ISP approach within 3 or 4 years.

Importance of Improved Access to Wrap Around Supports to Those Who Need Them
The current model of services for individuals with intellectual/developmental disabilities and mental health conditions means that some individuals whose health and residential/social situation would improve are not eligible for funding for needed wrap around services. Dion hopes that new financing and service delivery approaches of this project will be used to insure that more individuals who are dually eligible who would benefit from wraparound services (such as respite, case management and help with writing and budgeting, for example) are able to get these services. This will not address the needs of the full population of people with intellectual, mental health and other disabilities who need but are not eligible for services today. However, it could model what is possible when we use funds differently to help individuals succeed in managing both their health and their daily lives. If people had access to the right supports in the community, they would be more likely to succeed in managing their health, their finances and other activities when disability makes it difficult or impossible to do this without assistance.

Part D
Dion is glad that the project proposes improvements in how pharmacy coverage is managed as the Part D process has many problems.

Dental Coverages
Please add much needed dental coverage in this proposal. We need much flexibility and broad based funding to keep and bring in more dentists to Vermont. We need expanded coverage for preventative care such as filings, cleanings dentures etc. We also need to attract dentists coming out of school to the area of Vermont and offer incentives to keep them here.

And we need much needed more dental clinics in more communities to be able to serve more people.

Bottom line is we need more dentists in Vermont who are willing to participate in this program. As we have a lot of toothless Vermonters, as one has said, it is a shame.

(Summarized by Deborah Lisi-Baker)

Jackie Majoros, State Long Term Care Ombudsman

Vermont Legal Aid
PO 1367
Burlington, VT 05402

Here are some brief comments on the proposed draft:

1. **Section C.i. Proposed Delivery System.**
This section should clarify that beneficiaries will have the same right to choose providers that they currently have under federal law.

2. **Section G.i Expected Use of Contractors.**
H. 559 requires that the waiver include "an independent advocacy system for all participants and applicant." Although the details and scope of this system are yet to be determined, the proposal should acknowledge that the state will need to rely on contractors to provide the independence advocacy required under H.559. Like provider education and training, independent advocacy is a core element of the demonstration model.

3. **Section H.ii. Statutory/Regulatory Changes.**
The first sentence of this section is misleading. The legislature, through H.559, has identified changes to state statute that are necessary to move forward with implementation. This sentence should be omitted and the proposal should reflect the legislature's desire to give statutory guidance to the administration concerning public process, parameters of the waiver request and specific consumer protections.

John Barbour, Vermont Association of Area Agencies on Aging

Re: CMS Proposal to Integrate Care for Dual Eligible Individuals

Date: April 11, 2012

Thank you for the opportunity to comment on the Draft for Public Comment.

Page 9
Core Care Model Elements
We generally support the Core Care Model elements, including a single point of contact and a comprehensive person-directed care plan that addresses acute care, long term care and social supports. It is far easier to call for a person-directed care plan than it is to create one that will address all of these areas because there are often different perspectives that come from consumers, caregivers, and various providers. Any such a care plan needs to be created in a way that addresses these different perspectives, and is created in a collaborative manner that gives great credence to the wishes of the person at the center of the plan.

Also to bring this about Blueprint medical care homes would need to share information with Care Coordination Providers and Integrated Service Providers.

Care plans also need to be as holistic as possible. As Carmen Hooker Odom pointed out at the Vermont Blueprint for Health Conference, poverty is a major social determinant of good health but the focus of health care is largely on treatment of disease.

Medical Homes
Is it the expectation that every dual would have to be enrolled in an advanced primary care practice home? New practices, in particular, have to go through a certification process to obtain this designation. Would any dual currently with a practice that does not carry this designation have to choose a new PCP?

While we support the concept of medical home for most people, there are many people with particular conditions who rely primarily on specialists, most of whom are not Blueprint practices.

Medication Management Therapy
There is reference to a new medication management therapy program. Is there a specific program that is being envisioned?

Page 10 (and elsewhere)
Risk Sharing
At several points in the document it is said that ISP's will assume risk "for the full array of home and community based services and social supports;" and "the State will bear the risk for all other services (e.g. inpatient hospital, outpatient hospital, nursing facility, pharmacy."
Physicians' services, either by PCP or specialist, are not mentioned. Does this mean they fall within the risk that is carried by the State?

Page 16
Choices for Care
As you point out CFC has been very successful at decreasing utilization of nursing homes and increasing utilization of home and community based services. Much credit for this rests with the case management services provided by AAA's and home health agencies for many years. It would not make sense to make any change that would unintentionally disrupt similar success in the future. Earlier documents distributed at stakeholder meetings had stated that there would be no change in the way care management is provided to persons on Choices for Care.

PACE
It is unclear what the relationship is between PACE and the Duals Project. At times, it is implied that PACE is completely outside the Duals Project. Here it says that a PACE participant "could easily 'opt in' to the Demonstration program. Likewise a Dual eligible individuals could join the PACE program. Protocols will be developed to link consumers to both PACE Vermont and the Duals Demonstration program." Could one be in both PACE and the Duals Project at the same time? If a dual enrolls in PACE have they left the Duals Project? Does a PACE participant have to disenroll from PACE to be in the Duals Demonstration?
Since PACE is a Medicaid and Medicare funded program that draws from the same sources of funds that support other Choices for Care options, it would make sense to include financial information on PACE services.

Page 23
Capitated Rate for Choices for Care
We would urge caution as capitated rates are created for Choices for Care since, again, this program has been very effective at accomplishing its goals — supporting elders and persons with disabilities who choose to receive care and services at home, thereby reducing the cost of nursing home care.

Provider Payments
The statement is made that rates will be "at least comparable" to what providers would have received from Medicaid and Medicare in the absence of the initiative." There is concern in the Choices for Care program that rates may be reduced prior to the start of the Duals Demonstration. We hope that DVHA will coordinate with other state agencies to ensure that cuts will not be made that run counter to the goals of the duals project.

p.36
Request for Information for CCP and ISP
Hopefully DVHA will not require greater levels of credentials than it feels are necessary to carry out these activities. There are already competent providers of care management that are certified by the State of Vermont, and have staff who are experienced and skilled working with these populations. Whatever the process is for choosing future CCP's we do not want to run the risk of losing excellent providers who are already doing similar work.

John Pierce, MS Society

April 16, 2012

I think the draft does an excellent job of explaining vision, goals, objectives, principles, and outcomes etc. Nevertheless, the implications for the recipient, and the details of the financing model, are not very clear to me.

My comments relate to the written proposal itself, as opposed to the proposed project per se. I have found it difficult to grasp exactly how the project would work from the recipient's perspective. For example:

- Would I (as a recipient) relate to different people (either service providers or care managers) as compared to those I relate to now?
- Would my relationship to service providers/care managers be different than it is now in terms of such issues as my involvement in my treatment Plan? Would I find the changes advantageous? Or challenging?
- Would there be changes in the range of services available to me?
- How might the packages of services available to me be different in terms of timeliness? Flexibility? Co-payment? Deductibles?

Basically, as a recipient, how would I know that I was part of the "Duals" project?

I think answers to these sorts of questions would not only illustrate how the project would work from a recipient's point of view, but also imply how savings would be realized. At the last DAIL Advisory Board meeting, Bard gave the example of using Medicaid-type services to avert a Medicare-funded hospital admission. The Duals Project, since it pools both Medicare and Medicaid, would credit VT with savings associated with the averted admission. This makes good sense as an illustration of a consequence of the Duals Project. It is not however, necessarily a good illustration of how savings will be ultimately accomplished, because a prevented hospital admission does not automatically result in savings, if the hospital just spreads its costs over fewer bed-days. To achieve savings in hospital costs would require a reduction in the hospital's operating budget which translates into lower Medicaid/Medicare payments to the hospital.

A couple case examples illustrating various scenarios would be helpful, and if the case example also depicted how savings would be accrued, so much the better.

Vermont Council on Developmental and Mental Health Services

April 30, 2012

Julie Wasserman
Mark Larson, Commissioner
Department of Vermont Health Access
312 Hurricane Lane
Williston, VT05495

Dear Julie and Mark:

Thank you for the opportunity to provide feedback on Vermont's proposal to integrate care for people who are dually eligible for Medicaid and Medicare. We appreciate the level of input and feedback from stakeholders throughout the planning process and anticipate staying actively involved in the planning in the future.

The Council supports the goals to integrate care, improve outcomes and reduce costs for dual eligible individuals and want to work actively with state government as part of Vermont's health reform initiatives. We especially appreciate the opportunity offered to us to work with the Pacific Health Policy Group to develop an integrated service delivery model for the populations we serve.

The designated agencies provide a comprehensive array of services to people enrolled in our developmental services (DS) and community rehabilitation and treatment (CRT) programs, including service coordination, employment, housing, psychiatry, and assistance with integrated community living. We also serve a number of people in our outpatient services that are dually eligible and provide many of the same support services. The Council takes pride in our ability to provide quality services, in spite of several years of budget reductions and level funding.

We are eager to work with DVHA to advance our coordination with the Blueprint for Health and advance primary care practices. The Duals project, could offer one avenue to build on the coordination and integration with health care that already exists. However, we feel a sense of caution in relation to proposed savings, given the budget reductions we have experienced to date and the level of coordinated care we already offer. Potential savings from enhancing health care integration would more likely come from populations who don't have coordinated care through reductions in their use of prescription medication and hospital utilization of inpatient and emergency room use. In fact, we recommend investing greater resources into community services to achieve savings in acute health care and prescription medication.

Comprehensive care coordination provided to people enrolled in DS and CRT addresses an array of needs from supporting access to primary care providers, to helping someone find an apartment, to helping people to visit family or to transition home from a hospital. If the health

home were to be located elsewhere the people we serve would still need our services and then would experience
additional layers of coordination. Adding layers of coordination might be destabilizing for many of the people we support

In our DS and CRT programs we are already serving, to some degree, as health homes for consumers. We provide person-centered care which addresses the choices and needs of those we serve in a holistic way. Strongly held values lay the foundation of these services, including the avoidance of "medical models" of care. Designated agencies are in a good position to respect the values of those we serve, while improving health outcomes through improved integration with health care providers. Most of our consumers would prefer to have designated agencies serve as their health home, rather than having an advanced primary care practice or community health team in that role.

One option to strengthen our role as health homes would be to add more nursing staff to DAs to improve our expertise and coordination with the community health teams and advanced primary care practices. Nurses could assist with health coaching and strengthen the work of case managers in coordinating with health care providers. We want to ensure that the caseloads of service coordinators in the CRT and DS programs would be at appropriate levels to allow for coordination with health providers particularly advance primary care practices and community health teams. Additional resources identified through the Duals project could be utilized to enhance this ability.

The staff of designated agencies have unique training and expertise in meeting the needs of the populations we serve. Generic health teams would not have the expertise and knowledge that we have about conditions and disorders of our populations, including their unique communication needs, available resources and life experiences. Local standing committees within both CRT and DS that are comprised of people we directly support and their families actively advise us to ensure we are providing options that they find relevant to their needs.

Each DA and SSA must continue to serve as the ISP or CCP for the populations it serves in each region consistent with our statutory responsibilities. The implementation of the Dual Eligibles project should not result in the erosion of funding for the infrastructure or services provided by designated agencies. Please strengthen the commitment to utilize designated agencies in the language on page 9 of the draft proposal which reads:

Vermont's existing designated provider network, for each of the State's geographic areas, imposes some limits on choice by necessity, but where there are options, individuals will make the selection. The Dual Eligible Demonstration will build upon this foundation and seek to create more choice where opportunities exist.

Limited funding does restrict our ability to provide a full array of services in outpatient mental health. As a result these individuals may experience more unnecessary hospitalizations and other health interventions. The Dual Eligibles project should invest resources to build on our already

established programs, infrastructure and expertise to improve care management and promote bi-lateral integration for these individuals. Already, agencies are finding innovative ways to address primary health care needs at designated agencies. This would also be consistent with the goals of the new mental health
reform act which aims to better meet the needs of individuals with mental health conditions including those who do not yet meet the criteria for severe and persistent mental illness required for enrollment in CRT services.

The implementation of the Dual Eligibles project should not add complexity to the service delivery and financing of care. Considering that just over half of the people we serve in the DS and CRT programs and a smaller number of people served in our adult outpatient programs would fall into this program, it will be critical to maintain consistent service delivery to those inside and outside of the dual eligible program. Some people may change eligibility, without significant changes in service needs. Their care should be seamless and consistent and the administrative complexity for designated agencies should not lead to added costs and reduced direct care resources.

We want to work collaborative with DVHA to improve the well being and health of those we serve. Determining how to do that within the parameters of the demonstration program presents some unique opportunities and challenges. The next step will be to further the integration of our services with health care in a productive, cost-effective way which respects the values of the people we serve.

Again thank you for the opportunity to provide feedback on the proposal.

Sincerely,

Julie B. Tessler
Executive Director

March 2012

Generally we recommend that Medicaid rules should be used under the waiver. Here are specific recommendations.

Medicare coverage for intensive outpatient services, group therapy, support services, case management, telephone services (including for crisis care) and specialized rehabilitation.

Medicaid/Medicare reimbursement for hospital diversion services. Currently,
DAs receive case rate credit for CRT clients (only), and we are able to bill private insurance for about $250- 300 per day. Medicare does not even reimburse for the screening.

Medicare only credentials MD's, PhD's or social workers. Mental Health Counselors, Psychologist Masters, and substance abuse counselors are not eligible provider. If we include all

licensed providers then there will be considerable savings, because we won't be billing under the doctor's license.

Medicaid defines incident-to as in regular contact with the supervisor. Medicare requires the prescribing clinician to have an MD or a PhD and to be in the building for every appointment, as well as to have regular direct contact with the client. Medicare also requires a physician to see the person first, this should be waived, too.

Clinical services for individuals on a waiver – who have Medicare – are left off our spreadsheet to avoid the payback situation and the work involved with that. But the reimbursement is lower through Medicare. Agencies that include those services in the waiver and do the payback end up with more work, but a higher reimbursement – and the flexibility to move clinical dollars around to other people as needed. Both of these issues mean that more new DS caseload dollars are used statewide for clinical services than would need to be used.

Medicaid rates for physicians need to be competitive – no one wants to see people who have Medicaid – or they cap how many they will see.

The cap for Medicaid dental coverage needs to be increased from the current $495.00 cap. This will cover 2 cleanings and a couple of fillings, but the individuals we serve, who typically need more work done than this, are also the people who have no financial resources. Poor teeth lead to other health issue.

Dental care would be a good investment of the savings.

Lift Medicare rule requiring single service-per-day limit to either allow multiple services daily or up to a $700 daily limit like in VHAP and traditional Medicaid.

VHAP should allow applicable staff to be rostered annually instead of enrolling and re-enrolling as individual providers i.e. in Medicare, if the provider remains active and bills at least once every six months they do not need to reenroll. Invest savings into managing the unmanaged populations with complex needs. This would include individuals who are just miss the DS waiver eligibility and CRT eligibility requirements, including individuals who need intensive outpatient services or who have an array of acute medical and psychiatric conditions.

Maximus

As the scope and reach of the programs adminstered by the Department of Vermont Health Access (DVHA) have grown over the years, we have been a steady and reliable partner, meeting or exceeding our performance standards and showing flexibility, adaptability, and an unwavering commitment to the Vermonters who depend on your programs. MAXIMUS applauds the Dual Eligible Demonstration and supports Vermont's goals to integrate care, improve outcomes, and reduce costs for dually eligible Vermonters by delivering comprehensive, effective, and coordinated person-directed care. As a longstanding partner of the State's public Managed Care Entity (MCE), we support Vermont's commitment to the elderly and vulnerable population, many of whom we interact with today.

MAXIMUS Green Mountain Care Member Services is ready to build upon our existing operations by expanding our call center, customer services, and member services to serve the dual eligible demonstration project. Our call center can serve as a single point of customer assistance and member services where beneficiaries may call about eligibility, enrollment, benefits, and overall assistance with enrollment into primary care providers and care coordination entities. Through our experience doing so in many states across the nation, we are well acquainted with how to effectively serve this important population. In Vermont, we have provided member services for dual eligible beneficiaries enrolled in the Vermont pharmacy programs since 1996. The Demonstration will benefit from our deep understanding of Vermont, Vermonters, and the Vermont health care landscape gained from having worked closely with DVHA to support these programs for over 15 years.

MAXIMUS projects have played a signficiant role in the managed care expansion to dually eligible populations across the country in many ways. In states where we have existing project operations, we are able to provide scalable solutions to support a variety of expansion models and enrollment methodologies. For all, we provide a range of services including the following:
High touch member services
Outbound calling
Face to face and telephonic outreach and education
Enrollment and disenrollment
Exemption processing
Third party review
Materials development
Technology including information technology systems, telecommunications and interactive voice response systems, knowledge management systems, encounter tracking and reporting, consumer websites, and workflow management applications

Our capabilities include using data to match Medicaid plans/providers to Medicare plans/providers to ensure there is enhanced coordination and seamless health care coverage for dually eligible populations.

Our nationally recognized Center for Health Literacy (the Center) designs, tests, and produces informational and transactional websites and informational materials that are culturally and lingustically appropriate and Section 508 compliant. The Center develops notices, confirmation letters, and enrollment forms using plain language and initituative design. The Center also provides adapted translations to ensure non-English speaking beneficiaries can understand and act upon key messages and content.

MAXIMUS has been engaged in efforts across the nation to support states as they seek to increase coordination of care for the frail and vulnerable populations. By leveraging existing project infrastructure, we are able to offer significant cost-savings to our state partners. We fully anticipate that leveraging our current Green Mountain Member Services operations and services will promote a smooth and cost effective implementation of the Dual Eligible Demonstration project for Vermont.

Medicaid Advisory Board comments were generally supportive of the intent of the Dual Eligibles demonstration project, but members did express the following concerns at their 4/26/12 meeting and requested they be shared with the project policy makers in a timely manner for consideration:

1) (Sharon Henault) Changes as a result of this project should not exacerbate surviving spouse risk in losing his/her home. (Lori Collins and members remarked this is related to the state's recovery process when there are claims against estates, and should not be impacted by the Duals Project.)

2) (Julie Tessler) There seems to be a focus on a single point-of-contact. However, this concept is mostly centered in the medical realm. Measures need to be considered to be sure there is a connection to broader mental health care concerns. Members agreed the point of contact needs to be appropriate for a consumer's needs and trusted by the consumer.

3) (DaleHackett) The terminology/definition of the concept of "medically necessary" needs to be looked at and expanded. Under person-centered plans, better outcomes will require an expanded definition of "medically necessary."

4) (Larry Goetschius) Home health agencies are appreciative of an approach to align outcomes with payments. But there will likely need to be several Integrated Service Providers (ISP) (e.g. medical, mental health) in any given service area. Capitated reimbursement to providers is financially risky to providers when spread over a smaller population and smaller service area.

5) (Larry Goetschius) There must be a realistic and comprehensive way to identify and capture cost savings off the top. If a community produces significant savings, money needs to come back into that community, reflecting the savings.

6) (Kay Van Woert) Is there a way to use capitated payment from the feds but not necessarily rely on capitated payments to local providers? Or at least provide some pools for sharing risk? Medical necessity is medical necessity, not medical necessity within a dollar amount. It's hard for providers to absorb risk over a smaller population, and that can lead to consumers getting shortchanged on benefits they should be receiving as well as variation in benefits available depending on where a consumer lives.

7) (Laura Pelosi) The project proposal has not yet considered increased costs and additional requirements for providers. By adding the Duals Project, many providers including nursing homes will be operating under three sets of payment systems. Is there a suggestion/plan to mitigate this concern?

8) (Christina Colombe) Will participants work under a Medicare Part D Pharmaceutical formulary or a Medicaid formulary? Making a decision about whether to stay with the current system or the new one for Duals may be difficult for people with significant Rx challenges. The Medicare Rx benefits a consumer knows may be easier to stick with than experimenting with either the Medicaid (which changes constantly) or a new combined formulary. It would be better for consumer decision making to have the formulary be consistent throughout the year.

9) (Sharon Henault) As the project plans are drawn up, all aspects of the proposal need to be looked at through the eyes of the disabled and independent living needs. These vantage points must be considered and included.

PhRMA

April 27, 2012

Julie Wasserman
Department of Vermont Health Access
312 Hurricane Lane
Williston, VT 05495

VIA ELECTRONIC SUBMISSION

Re: State Demonstration to Integrate Care for Individuals Eligible for Medicare and Medicaid

Dear Ms. Wasserman:

The Pharmaceutical Research and Manufacturers of America ("PhRMA") appreciates the opportunity to submit comments regarding the Vermont Demonstration to Integrate Care for Medicare-Medicaid Enrollees.[1] PhRMA is a voluntary nonprofit organization representing the country's leading research-based pharmaceutical and biotechnology companies, which are devoted to inventing medicines that allow patients to lead longer, healthier, and more productive lives. PhRMA companies are leading the way in the search for cures.

PhRMA supports efforts to provide more "comprehensive, effective and coordinated person-directed care" for individuals dually eligible for Medicare and Medicaid ("dual eligible beneficiaries" or "duals") in order to improve health outcomes for this population while at the same time reducing unnecessary costs. PhRMA also appreciates the State's clear recognition, articulated in the principles set forth in the pending Vermont House Bill H. 559, that integration of care for duals must not reduce access to health care services or continuity of care for this extremely vulnerable population.[2] However, we believe that Vermont's proposed approach for providing pharmacy coverage in this demonstration will seriously disrupt access to prescription drugs for both dual eligible and other Medicare beneficiaries in Vermont, will undermine the success of the Medicare Part D program, and is not consistent with the law. Accordingly, we strongly oppose Vermont's proposed approach.

We note at the outset that Vermont's proposal seems not to be based on the needs of this population, so much as an effort to use this population (and Medicare funds) as the first step in its establishment of a single payer health care system that will supplant the insurance market in the state. Specifically, Vermont proposes to establish a single pharmacy benefit for all dual eligible beneficiaries based on its restrictive Vermont Medicaid pharmacy benefit and Preferred Drug List ("PDL"), replacing the 30 different prescription drug plan options currently available to dual eligible individuals through Medicare Part D.[3] Further, the proposal appears to contemplate that this pharmacy benefit plan will be administered by Vermont's "public managed

[1] Vermont's Demonstration Grant to Integrate Care for Dual Eligible Individuals: Draft for Public Comment. (Mar. 30, 2012), (hereinafter "Vermont Proposal"), *available at* http://humanservices.vermont.gov/dual-eligibles-project/proposal-vermonts-demonstration-grant-to-integrate-care-for-dual-eligible-individuals/view .
[2] H. 559 § 33 (a)(3)(B),(C),(F).
[3] Vermont Proposal at 9.

care entity" ("MCE"), the Department of Vermont Health Access ("DVHA").[4] Such a proposal would curtail beneficiary choice for prescription drug benefits and reduce access to needed medicines. In addition, the proposal is wholly inconsistent with the Social Security Act provisions governing Medicare Part D benefits and beneficiary protections, the prohibition on a direct government role in determining the formulary, guidance from the Centers for Medicare and Medicaid Services ("CMS"), and the competitive approach based on beneficiary choice that has made Part D successful.

Vermont's quest to establish the first single payer, state run health care system supplanting the existing health care system in the US should not be tested first on medically-fragile and medically-dependent dual eligible beneficiaries. We strongly recommend that Vermont revise its proposal to:

Eliminate the proposal to establish a single, state-wide formulary based on the State's PDL, as this approach is inconsistent with the Social Security Act, the CMS Guidance, and principles that underlie the success of the Part D program;
Recast the proposal as a managed fee-for-service option as the proposed approach is wholly inconsistent with the July State Medicaid Director letter on the financial models for duals integration and the guidance laid out by CMS for states relying on capitated plans. Under a managed fee for service option, beneficiaries should remain in their current Part D plans.
In the absence of such revisions to Vermont's proposal, we cannot support the proposed demonstration and would recommend to CMS that the proposal be denied.

Imposing a Single State-wide Formulary Is Inconsistent with Part D Benefits and Protections

CMS has indicated multiple times that all health plans interested in participating in a given state's duals demonstration should meet all Part D requirements regarding formularies. It stated this first in its *Letter to Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans in Interested States,* issued to plans on January 25, 2012 (the "January CMS Duals Guidance").[5] CMS reiterated this basic requirement in its *Additional Guidance on the Medicare Plan Selection Process for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans in 2013* issued to plans on March 29, 2012 (the "March CMS Duals Guidance"). The March CMS Duals Guidance stated that to be qualified to participate in a state's demonstration project, interested organizations must meet certain Medicare requirements for prescription drug benefits, including obtaining CMS approval of "a formulary consistent with Part D requirements, approval of a medication therapy management program ("MTMP") consistent with Part D requirements; approval of a demonstration specific application, including demonstration of adequate access to providers and pharmacies for Medicare drug and medical benefits..."[6] The CMS guidance clearly contemplates that for each State demonstration, it will be evaluating *multiple* plans to ensure that the plans that are

[4] *Id.* at 32, 35. Note that the alleged public MCE is in fact the State agency that administers Vermont's Medicaid program under existing waivers of federal Medicaid law.
[5] January CMS Duals Guidance at 4, 5.
[6] March CMS Duals Guidance at 2; *see also id.* at 3–10.

ultimately selected for purposes of the demonstration provide robust prescription drug coverage for dual eligible beneficiaries and include models of care that appropriately target the duals population while satisfying the eleven clinical and non-clinical elements required by CMS as well as any *additional* State requirements.[7] In this way, the CMS guidance preserves the fundamental characteristics of the Part D program, as enacted by Congress.

Notwithstanding this clear guidance, Vermont proposes an approach that is fundamentally incompatible with the principles outlined by CMS. As noted above, the Vermont proposal would establish a single statewide formulary based on the State's PDL for Medicaid, to be administered by DVHA (a State agency).[8] Although the Vermont Work Plan and Timeline attached to the proposal say that the State intends for the single statewide formulary to meet Medicare Advantage-Prescription Drug ("MA-PD") plan requirements and that it (the State) will submit an application to be an MA-PD plan for Calendar Year 2014,[9] that does not change the fact that the unilateral imposition of a uniform formulary determined by the state under Medicaid's PDL principles is at odds with the fundamental underpinnings of both Medicare Part D and Medicare Advantage, both of which rely on voluntary enrollment and market competition between health plans in order to balance broad access with cost savings. Vermont's proposed approach eliminates all competition and beneficiary choice among health plans for pharmacy (as well as other) coverage. Such an approach violates a fundamental tenet of the Affordable Care Act that nothing in the law "shall result in a reduction of guaranteed benefits under [Medicare]."[10] The choice of plans is a fundamental guaranteed Part D benefit.

Since 2006, the Medicare Part D prescription drug program has effectively provided access to robust prescription drug coverage for Medicare beneficiaries, with high levels of beneficiary satisfaction, and at far lower costs than initially projected.[11] It has also resulted in substantial savings for other parts of the Medicare program; a recent study published by the Journal of the American Medical Association ("JAMA") found annual savings of $1,200 on other, non-drug Medicare costs for seniors who previously had no drug coverage or limited drug coverage prior to the creation of Medicare Part D.[12] GAO, the Medicare Trustees, and the HHS Office of Inspector General have all reported that competition between plans, and in particular competing plans' ability to negotiate with manufacturers to determine prescription drug prices (including rebates negotiated directly with manufacturers such as those negotiated in exchange for a drug's placement as a preferred drug on the plan's formulary), have an important impact on lowering plan premiums for beneficiaries.[13] The Vermont proposal would eliminate all of that competition between plans, and thus may put these savings at risk and instead result in higher drug prices, and/or reduced access to needed medicines.

Moreover, the Vermont proposal does not provide any detail regarding how it will ensure that the formulary established by DVHA based on the State's Medicaid PDL will meet the Part D requirements. The proposal states that Vermont believes it needs a waiver from premium rules, but in fact it likely would need multiple waivers, including those related to choice of at least two plans, standards for

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[7] *Id.* at 7–9 (emphasis added).
[8] Vermont Proposal at 32, 35. Note that this contractor is already obligated to the State under contracts providing for the State Medicaid benefit; CMS apparently would not be evaluating the contractor or having any means of holding it accountable for the standards of care under Part D.
[9] Vermont Proposal, Appendix 4.
[10] Patient Protection and Affordable Care Act, Section 3601(a).
[11] *See e.g.*, CBO, "Updated budget Projections: Fiscal Years 2012 to 2022" March 2012. P. 9. See also, CMS Press Release, "Medicare Prescription Drug Premiums Will Not Increase, More Seniors Receiving Free Preventive Care, Discounts in Donut Hole.: August 4, 2011.
[12] J.M. McWilliams, et al., Implementation of Medicare Part D and Nondrug Medical Spending for Elderly Adults with Limited Prior Drug Coverage, Journal of the American Medical Association (July 27, 2011).
[13] Government Accountability Office. "Overview of Approaches to Control Prescription Drug Spending in Federal Programs." Statement of John E. Dicken Director, Health Care, before the Subcommittee on Federal Workforce, Postal Service, and the District of Columbia, Committee on Oversight and Government Reform, House of Representatives, June 24, 2009; The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. "2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds." August 5, 2010; Department of Health and Human Services Office of the Inspector General. "Concerns with Rebates in the Medicare Part D Program." March 2011.

Pharmacy and Therapeutic Committees, and others. The Vermont PDL applies to the state's Medicaid prescription drug program, which serves a wholly different patient population, with different medical needs than duals. In marked contrast to the Medicaid PDL, Part D requirements were developed taking the needs of duals and the entire Medicare population into account. Indeed, at the time of Part D's enactment, beneficiary advocates campaigned to let dual eligible beneficiaries receive drug benefits in Part D rather than Medicaid.[14]

We further note that the Vermont Medicaid PDL differs in important ways from formularies typically used in Part D, which typically make more medicines available without prior authorization. As a result, use of the PDL would likely require many more Vermont beneficiaries and their providers to go through a prior authorization process to continue on their current medications. For example, a comparison of the Medicaid PDL with the formularies of the five Part D plans enrolling 90 percent of Vermont's dual eligibles shows that approximately half of atypical antipsychotics are denoted as nonpreferred agents on the PDL, posing limitations to patient access to these medicines, while they are generally available in PDPs. Similarly, seven antidiabetic agents (representing a range of newer therapeutic options) are restricted on the PDL but available without restriction in at least four of the five PDPs. In fact, in the case of one PDP with significant dual eligible enrollment, the PDP formulary includes more than 100 additional preferred drugs across classes used to treat diabetes, pulmonary disease, stroke, anticonvulsants, antidepressants, and antipsychotics. Such differences in coverage translate into significant disruptions in care; in the top five PDPs, enrollees taking from 15 up to 38 different commonly used medicines would need to make a change in therapy, depending on their current PDP formulary, if they were switched to the Medicaid PDL.

Vermont has not offered any indication as to how it will reconcile these and other profound gaps between the Medicaid PDL and the benefits and protections available under Part D. Although the proposal acknowledges that this proposal will increase the workload for its current PBM contractor, including "increasing workload in the clinical call center that manages prior authorization" and requiring pharmacy reporting to be modified,[15] the State does not offer any information regarding whether DVHA has experience managing the other requirements set forth in the CMS guidance, such as the model of care, or how DVHA will meet such requirements. Nor does the Vermont proposal state that the PBM contractor will comply with the March CMS Guidance, or address how the pharmacy benefit will be administered in the event that DVHA cannot meet the requirements spelled out in the CMS plan selection process, as discussed in the CMS March Guidance. Given that the Vermont proposal depends on the "public MCE" (i.e., the state agency) being approved as the only Part D plan to cover duals in the state, PhRMA believes that the Vermont proposal must clearly address these concerns in order for CMS to even consider its proposal. More fundamentally, Vermont apparently would make a state agency (the DVHA, the "public MCE") the sponsor of the demonstration plan. However, the Medicare statute requires that Part D sponsors be nongovernmental entities.[16]

Dual eligible beneficiaries have been well served by Medicare Part D and should have access to the same breadth of coverage available to higher income Medicare beneficiaries. Using the Vermont PDL as the basis for pharmacy coverage for duals is a one-size-fits-all approach and it runs the unacceptable risk of establishing an inappropriate standard of care for the population. Moreover, Vermont's proposal does not adequately demonstrate how it will ensure that its approach will not result in reduced benefits and protections for dual eligible beneficiaries.

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[14] *See* "The Six Million Medicare Beneficiaries Excluded From Prescription Drug Benefits Under the Senate Bill are Disproportionately Minority," Leighton Ku and Matthew Broaddus, Center on Budget and Policy Priorities, September 9, 2003; and AARP News Release, 'Letter by AARP CEO Bill Novelli to Congress Concerning Prescription Drug Benefit in Medicare," July 14, 2003.

[15] *Id.*

[16] Social Security Act (SSA) § 1860D-41(13).

PhRMA urges Vermont to revise its proposed approach to ensure that dual eligible may continue to receive their pharmacy benefits through their current Part D plan. Alternatively, if necessary, Vermont could assist with the assignment of enrollees to Part D plans with formularies that met their medical needs, as has been successful in assuring continuity of care in both Pennsylvania and Maine.

Vermont Should Clearly Delineate Between Medicaid and Dual Eligibles in Its Administration and Financing of the Prescription Drug Benefit

The Vermont proposal does not clearly explain whether, under its proposed approach to have DVHA administer both the Medicaid PDL, the Medicaid drug benefit, and the duals' prescription drug benefit, it is proposing to group dual eligible beneficiaries into the same prescription drug benefit pool with Medicaid beneficiaries. This would not be permissible under federal law. Outpatient prescription drugs are a Medicare-covered benefit for dual eligible beneficiaries and may not be paid for by Medicaid.[17] Thus Vermont may not collect a statutory Medicaid rebate on the drugs dispensed to dual eligible beneficiaries and may not use the single Medicaid formulary to try obtain such a rebate. PhRMA urges the State to set out clear rules for any plan to maintain separate benefits and separate claims data for the two populations. Moreover, Vermont must ensure that Part D beneficiaries are in a "Part D plan" so that any rebates and discounts negotiated with drug manufacturers are exempted from the Best Price provisions of the Medicaid drug rebate statute.[18] Under federal law, the rebates between manufacturers and Part D plans and MA-PD plans for Part D drugs are exempted from the best price calculation and the policy of that exemption should be continued.[19]

For these reasons, it is critical for the State to keep records of prescription drug utilization, and to maintain prescription drug claims data and other records for Medicaid beneficiaries separately from the Medicare Part D claims data for dual eligible beneficiaries.

Vermont Should Recast its Proposal to Accurately Reflect its Characteristics as a Managed Fee-For-Service Model, Rather than as a Capitated Financial Model

Vermont says that its proposal falls under the capitated payment financial model outlined by CMS, in which DVHA, as the public MCE, will enter into a three-way contract with CMS and the State Agency of Human Services and will receive capitated payments and bear the risk of fully integrated services for dual eligible beneficiaries.[20] The claim that the proposal involves a three-way contract is a fiction, as two of the parties to the proposed contract with CMS are in fact, agencies of the State of Vermont – one is its Agency of Human Services, and the other is the single state agency for Medicaid, DVHA, here called the "public MCE."

Vermont is not entering into the type of capitated arrangement with commercial health plans that is the foundation of the CMS guidance with respect to its test of the capitated financial alignment model. Instead, Vermont will be acting with the full force of a government entity – the State government will be fully responsible for duals' care and for receipt of Medicare and Medicaid funding. It seems obvious that Vermont prefers this fictional approach to a managed FFS approach which only allows the State to share savings retroactively. Nevertheless, Vermont's capitated proposal, which contemplates the state receiving the capitated payment, would allow the State to directly take over Medicare funds in a way that is not consistent with what CMS has discussed in connection with the managed FFS proposal.

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[17] SSA § 1935(d).
[18] SSA § 1927(c)(1)(C)(i)(VI).
[19] *See, e.g.*, H. Rep. 107-539, at 110; H.Rep 108-178 (11), at 145-46; H.R. Rep 108-178(ii), at 154-55.
[20] Vermont Proposal at 22.

The CMS guidance for the capitated proposal clearly contemplates that CMS will have an opportunity to evaluate and score multiple plans pursuant to a competitive joint procurement by CMS and the State to ensure that any organization that is approved to participate in the demonstration can satisfy the Part D requirements,[21] including that CMS and the State will also have an opportunity to jointly review each plan's proposed model of care and any exceptions requests to the Part D requirements. Vermont would circumvent this CMS quality control process by substituting an agency of a sovereign state as the "public managed care entity" that would receive the capitated payment of Medicare and federal Medicaid funding.

It seems obvious that a handover of federal funds on this scale to a state that proposes to create a system in which its citizens have no choice of private health coverage, but instead are wholly dependent on a state-run system, far exceeds what Congress anticipated in establishing authority for CMS to use federal funds in limited "demonstration" programs designed to discover ways of better coordinating the multiple health care needs of the dual eligible population. Nor is there any experimental or demonstration aspect to this proposal: the proposal is aimed at moving Vermont to a state-run or single-payer system, not comparing the results of multiple duals demonstration plans, or comparing the results of demonstration plans with non-demonstration service delivery models in an effort to learn what works best to improve dual eligibles' health.

Medicare beneficiaries do not lose their rights under federal law simply because they are so ill or impoverished that they also qualify for the state-operated Medicaid program. For this reason, as well as the others enumerated above, unless Vermont substantially revises its proposal to preserve the rights of beneficiaries to obtain Medicare-covered benefits under Medicare Parts A, B, (or C), and D while adding coordination and alignment with benefits covered by the State Medicaid program, we will recommend to CMS that it be rejected as exceeding its authority under the federal law.

We thank you for your consideration of these comments on Vermont's Demonstration to Integrate Care for Dual Eligible Individuals. We urge Vermont to revise its proposal in a manner that enhances coordinated care without either unnecessarily disrupting care for Vermont's most vulnerable beneficiaries, or compromising Medicare prescription drug benefits for all Medicare beneficiaries in the State. We look forward to the opportunity to continue working with Vermont in its development of this demonstration. Please contact me if you have any questions regarding these comments. Thank you again for your attention to these important issues.

[21] *See* CMS March Guidance at 8; CMS, Capitated Financial Alignment Demonstration Application.

State Health Care Ombudsman

April 27, 2012

Julie Wasserman
DVHA
312 Hurricane Lane
Williston, VT 05495

Re: Vermont's Demonstration Grant to Integrate Care for Dual Eligible Individuals
Proposal to the Center for Medicare and Medicaid Innovation

Via email

Dear Julie:

The Office of Health Care Ombudsman (HCO) generally supports Vermont's proposal to integrate care for dual eligibles. We think it holds tremendous promise to improve the lives of a very vulnerable and medically needy group of Vermonters, but the devil is always in the details.

It is especially important to us that the state be the managed care entity, rather than a private sector managed care organization. The HCO works with consumers on both commercial and public program insurance. Our experience is that it is much easier to resolve consumer problems with the sate than it is with the private carriers in Vermont. We have a reasonable degree of confidence in DVHA to develop and implement the proposal in a way that will involve stakeholders and result in better care for participants.

The HCO has been involved in the stakeholder group that has been working on this proposal for months. We plan to stay involved as the proposal progresses through the CMS review process, and appreciate DVHA's continued willingness to listen to so many stakeholders.

DVHA has worked cooperatively with the HCO and other advocates to develop consumer protections in the authorizing legislation, H. 559, An Act Relating to Health Care Reform Implementation. All the various protections in Section 33 of H. 559, attached to the proposal as an appendix, should also be clearly spelled out in the proposal.
As written in the Stakeholder Engagement and Beneficiary Protections section of the proposal (section D, page 21) several negotiated protections from H. 559 are omitted, including:

- Guarantee of choice of provider in and outside of the individual's integrated service provider (ISP). It is very important that participants have sufficient choice of options. This is a vulnerable group who often establish intimate connections with their caregivers, so the ability to keep longstanding caregivers can be extremely important. Elsewhere in the proposal the choice of primary care provider choice is mentioned, but it should be made clearer that this choice extends to other types of providers as well. In particular, we have some concerns about how the single point of contact will work if participants don't have a choice. The providers who deal with different populations have different kinds of expertise. For example, developmentally disabled individuals need different types of services, interactions and supports than those with severe and persistent mental illness, or those whose primary needs are home care. A medical orientation for the coordinator is not the best for every individual.

- Reinvestment of at least 50% of the remaining funds to enhance the program. Not all of the state savings should just accrue to the state. At least half of any savings should be put into the program to improve the lives of the beneficiaries.
- Require the ISPs to provide a broad range of services and coordinate with other service providers.
- Enforcement mechanism to ensure the ISPs and subcontractors provide integrated services. There must be a way for the state to hold the ISPs accountable for any failure to provide services or high quality services. Clear quality assurance measures must be in place as well. The measures should not just rely on reduced utilization and aggregate statistics, but should also include spot checks with participants about their perceptions about the care they are receiving. The ISPs will be bearing some financial risk and thus will have some incentive to cut corners and limit care. It is critical that the emphasis be on high quality care that improves the lives of the participants, and there must be a clear enforcement mechanism if that doesn't happen.

The HCO and other projects within Vermont Legal Aid are now participating in the work group working on the development of the integrated appeals process, and we plan to continue that participation. We do not want participants to give up any existing rights that they have now. One example is the right to continuing benefits that Medicaid beneficiaries have pending the outcome of a fair hearing.

Finally, it is very important that participants have access to adequate counseling, education, independent advocacy, legal advice and legal representation as this project is implemented. This is included as a beneficiary protection in the proposal, but we want to emphasize it here. Transitions are difficult for many people, and will be particularly so for this population. There must be sufficient funding for all levels of advocacy.
Thank you for this opportunity to comment.

Sincerely,

Trinka Kerr
State Health Care Ombudsman

VAHHA

DATE: April 27, 2012

On behalf of the eleven members of the Vermont Assembly of Home Health and Hospice Agencies, please consider the following comments on the draft proposal "Vermont's Demonstration Grant to Integrate Care for Dual Eligible Individuals".

VAHHA members agree that combining the care and financing for dually eligible Medicare/ Medicaid patients, particularly those with complex and intensive needs, makes sense. There is compelling evidence that the current system is inefficient and costly. Combining the two programs for the 22,000 dually eligible Vermonters should improve both quality of care and patients' outcomes and produce cost-savings. VAHHA has been a strong advocate for coordinated care and payment innovation and will likely join other organizations such as SASH to present an ISP proposal provided the issues expressed below are addressed.

CCP/ISP - "The core of this plan is the Care Coordination Providers and Integrated Service Providers. Will there be more than one CCP or ISP per region?" VAHHA supports having only one ISP per region otherwise there will be no incentive for providers to join the ISP. If there are more than one, will patients be able to switch from one ISP to another, and, if so, how frequently? VAHHA suggests that patients not be allowed to switch from one program to another for at least six months per program enrollment otherwise management of the program would be very difficult.

Risk - "The primary distinction between a CCP and an ISP is that the ISPs will operate under a risk bearing model which requires providers to take management responsibility and financial risk for the full array of home and community-based services and social supports (page 10)." Due to the fact that the population for any ISP would be very small, especially if there is more than one ISP per region, the State should guarantee "risk loss corridors" where the State would pay for losses that exceed a negotiated loss percentage. The financial risk of this program is unknown and if the project costs are considerably higher than expected, without a loss limit guarantee, the ISP could face financial ruin. Multiply ISPs per region will make success less likely.

Care Management - Neither the CCP nor the ISP system will work unless the providers have the ability to "manage" the care delivered by making care decisions based on the care needs of the patients rather than on a set of rules and requirements that forced the delivery of unnecessary care.
HIT - "Improve sharing of health records, assessments and information (page 9)." Home care has not been considered "meaningful use" by the federal government. In order for this system to work, home care must be included in all Health Information Technology reform.

Performance Measures - "Development of performance and outcome measures linked to payment reform for providers (pages 9 + 11)". VAHHA members support the move toward performance measures (Medicare has done this for several years) but caution that this is a complicated task and that any measures approved must consider variations of population, geography and services available. In addition, any data collected should be comparable to similar national data.

Services Provided - This project should not reduce the amount, duration or scope of services provided as required by H. 599. In addition, this program should not be an opportunity to reduce payments to providers.

Utilization - “A core element of Vermont’s proposal is to identify patterns of over utilization (page 9).” The State should be equally concerned about patterns of underutilization.

Details - The draft proposal is lacking enough details to determine whether this proposal could work especially concerning projections for system-wide savings. The payment methodology, including any performance based adjustments, are central to the operation and viability of the proposal, yet there are no details in this proposal about how this would work.

Individual assessments - “Individual assessments results in comprehensive person-directed care plans across acute, long term care and social supports (page 9).” This program should not set up a parallel system that duplicates what already is done.

Program Focus - This program will cover all community-based services except “inpatient hospital, outpatient hospital, nursing facility, pharmacy” (page 10). Clearly mental health and home health would be the dominate service providers for this program and that should be reflected in this document, which it is not. Concerning community-based, non-mental health services, home health and hospice should be the main focus of this proposal as, both in terms of people served and dollars spent, home health and hospice are the two prominent programs. Home care agencies provide home visits to 20,000+ Vermonters with total revenues at $110 million.

Rules - How will the program resolve the differences between the Medicare and Medicaid rules and will the program result in fewer regulations? VAHHA suggest that this project should not result in increased administrative and regulatory cost.

Medicaid Tax - How will the State deal with the Medicaid tax on home care? Currently, home health agencies are taxed on Medicaid revenues but not Medicare revenues. If the Medicare revenues for the dually eligible are added to the tax base, this would add substantially to the home tax, money the agencies cannot afford, and would increases the losses to the agencies.
Rules - The home care rules for Medicaid and Medicare eligibility are different. To qualify for Medicare services a patient must be “homebound”, basically unable to leave his home without assistance. Homebound is not a Medicaid requirement. How will this difference be resolved?

Savings - One major goal of the project is to create savings both for the State and Federal governments. How will these savings be calculated? If there are savings, how will the State determine what caused the savings? Also, how will the savings be utilized? VAHHA recommends any savings be used for new or noncovered services.”

VCIL

April 27, 2012

Comments on the Preliminary Draft of Vermont's Demonstration Grant to Integrate Care for Dual Eligible Individuals

Submitted by the Vermont Center for Independent Living

The Vermont Center for Independent Living (VCIL) is a cross-disability rights organization of people with disabilities working together for dignity, independence and civil rights.

The Vermont Center for Independent Living (VCIL) has reviewed the Preliminary Draft for Stakeholder Comment. VCIL supports the concept in general but has some concerns. VCIL has been in contact with other disability rights organizations from around the country who are also working on Dual Eligible issues. Those organizations include the National Council on Independent Living, Disability Rights Education and Defense Fund, Boston Center for Independent Living, Community Catalyst and Tri-County Independent Living Center. Those groups have developed a set of principles for Dual Eligible Integration Policy Initiatives.
The term "community- based long term supportive services" encompasses the full gamut of medical and functional assistance services needed by individuals to live safely, live well, and with maximum independence in their own homes and communities throughout their lifespan.

The principles include:

CHOICE
Individuals have the right to choose where, how and from whom they receive their services. The opportunity to live independently in an apartment or home, to be employed, to be engaged in the community with family and friends, to pursue personal activities, and to set one's own schedule is not to be determined by an individual's physical or mental health status or functional capacity.

COMMUNITY-BASED LONG TERM SUPORTS AND SERVICES
Individuals have a RIGHT to community-based long term supportive services (CVLTSS) that are readily available, consumer directed and of sufficient scope to support independent living in the community.

DO NO HARM
Individuals cannot be forced to bear the possible consequences as the short or long term interruption of needed provider relations, reduced or lost services and benefits, inadequate coverage of services in both scope and levels and fear of unknown disruptions as the State integrates this highly complex program that attempts to align discrete Medicaid and Medicare funding and service streams.

INDIVIDUAL AT THE CENTER
The individual's needs and experiences must be the very core to every aspect of this policy initiative design. Service coordination and CBLTSS must inform and build upon individuals' need and capacity for self directed care and independent living within their own homes and chosen communities.

MEANINGFUL COMMUNICATION AND INPUT
Individuals have the right to effective communication of all outreach information, general enrollee and beneficiary communications, and individual notices concerning either their health or policy initiatives and procedures. This principle applies to all communication: by mail, in person, electronically, by phone or any other technological process. Once enrolled in new programs, beneficiaries must have meaningful and ongoing dialogue to provide input into program governance, policy and direction.

PRESERVING ESTABLISHED PROVIDER RELATIONS
Individuals have a right to continue to relations with their established providers as well as creating new forms of service delivery that is always peer directed.

NON-DISCRIMINATION
Individuals have the right to receive non-discriminatory and effective healthcare and services that fully complies with applicable federal and state laws which includes physical and program accessibility, cultural and linguistic competency and appropriate specialist expertise in all aspects and levels of service delivery.

CONSUMER PROTECTION
Individuals have the right to consumer protections including strong state and federal administrative complaint mechanism and recourse to state and federal anti-discrimination law without the need for administrative exhaustion, as well as requirements directed at the critical components of network adequacy, cultural and linguistic competency, peer input, strong oversight and enforcement, and the ongoing collection and development of real time and beneficiary oriented data measures that track successful health outcomes and the maintenance of living independently in their own homes and communities.

FINANCING AND PAYMENT
Initiative financing and payment structures must be transparent and cannot give providers an incentive for denying or minimizing the services and care needed by individuals, or give the state the opportunity to use federal funding to supplement Medicaid. Reinvestment of short or long term savings from integration shall be reinvested in the expansion of CBLTSS and a range of alternative services that further increase the opportunities for participants to live in the most integrated, least restrictive environment as set forth the Vermont's Olmstead Plan.
Individuals must be allowed to opt in to the new initiatives rather than being forced to opt out.
In addition to these concepts, VCIL is submitting the proposal back with comments embedded the document. VCIL believes the language of mental health issues and substance abuse should be separate, even if it is the language that CMS uses.
Also, VCIL believes that "person-directed" instead of "person-centered" should be used throughout the document.

Finally, VCIL is a member of the Vermont Aging & Disability Resource Connection and believes that the ADRC should play a role in the project.

Thank you for the opportunity to submit comments.

Yours truly,

Sarah Launderville
Executive Director

Vermont DD Council

TO: VT Dept. of Vermont Health Access
ATT: Julie Wasserman

RE: Draft for Public Comment ~ Vermont's Demonstration Grant to Integrate Care for Dual Eligible Individuals, March 30, 2012

FROM: Karen Schwartz, Executive Director

DATE: April 30, 2012

Thank you for this opportunity to comment on the Draft Proposal.

These comments are being submitted from the perspective of VTDDC's constituency – Vermonters with intellectual and other developmental disabilities, and their families. The estimate is that about 60% of people currently being served through the developmental service home and community based program are "dually eligible" for Medicare and Medicaid, either through their parents OASDI or SSDI benefits, or through their own work that led to eligibility for SSDI benefits. Since Vermont serves only about 29% of those who meet its narrow state definition of intellectual disability, it is likely that additional people with intellectual and other developmental disabilities fall within the non-specialized program" high users group.

The Proposal has great potential to address key needs Vermonters with developmental disabilities and their families expressed to us during extensive outreach in 2011 to develop VTDDC's current 5 year State Plan. It was clear that people wanted to be able to exercise more control and direction over their services and supports. They told us they needed more options, choices and flexibility; more opportunities to participate in their community, better connections with medical providers who understood them, and greater access to information and support to navigate complex systems of care.

These comments are made in the spirit of moving towards a system of care that can better meet people's needs while providing quality cost effective care.

Key things we are concerned about:

At a number of key points the Proposal seems to have lost its focus on the people who are supposed to be the intended beneficiaries.

There is no mention of beneficiaries and/or their satisfaction in sections about rewards for providers for value and quality of services (see p. 17 paragraph 2) or related to performance measures at page 24 paragraph 2.)

Beneficiaries are not named as a key group in the section on expected outcomes. See page 24 paragraph 1 and 4.

Flexibility is mentioned at a number of points related to services and providers, but not people. See page 23 last paragraph;

It appears that reinvestments will be directed to systems enhancements, and not to directly benefit people who are served. See page 11 at iii. There should be a clearer statement that reinvestments will benefit people.

ADDITIONAL RECOMMENDATION:

1. Check for People First language throughout. For example, at page 15 top, replace "the disabled" with "people with disabilities, and at paragraph 3, replace with "children with disabilities".
2. Although the Proposal mentions the need for a holistic model that serves individuals and families (page 15 paragraph 4) families are largely left out. That also is not consistent with Vermont's Developmental Disabilities Act, 18 VSA 8721. For example, the description of developmental services at page 12 notes that people live in their own homes and with home providers, but does not mention that over 700 people live with their families – many of them aging parents -- or that the system also provides family supports.
3. Although "person-directed services" are mentioned as the "centerpiece" of the system at page 9 paragraph 2, the Proposal describes a provider-centric system driven by care coordinators. There is virtually no mention of individual or family-directed options.
4. The Proposal does not adequately address the limits to choice and options imposed on participants by Vermont's designated provider systems, and ways to this issue of fundamental equity can be remedied. See page 9 paragraph 3.
5. The Proposal mentions community living, but overall has a medical focus that does not seem to adequately take into account key needs related to community living that are essential to long term care for people with developmental disabilities.
6. It speaks solely to health outcomes at page 11, paragraph 2
7. It appears to be built on the assumption that less utilization [volume] is always better. There does not appear to be recognition that quality of life for people with developmental disabilities may in fact depend on a "volume" of direct support services sufficient for participation in the community, and that people may need 24/7 supervision. [See p. 17 3rd paragraph; p. 23 last paragraph.

RECOMMENDATION: Performance measures need to address beneficiary quality of life and satisfaction. Vermont should renew its participation in National Core Indicators Project. Used by over 20 states, it assesses developmental services, and includes a consumer survey that is a model for assessing quality of life.

Given the language related to reducing utilization, there do not appear to be sufficient safeguards to prevent CCP's and ISPs from being "gatekeepers", as promised at page 10 paragraph 4. In point of fact, designated agencies now serve as gatekeepers for developmental services, performing intake, setting funding and service packages as well as providing services.

Staffing related to beneficiaries focuses on legal services and advocacy. There also needs to be investment in providing information and assistance to individuals and families to understand options and choices (including opting out) and to navigate the system of care. See page 35.

Information and assistance is a core need mentioned in every major study and report, including the Olmstead Commission, Real Choices Grant, as well as recent VTDDC survey and forums. There is no equivalent to the Area Offices of Aging in the developmental service system that can provide unbiased information and navigation separate from direct service provision.
Peers, including families, could provide be cost effective information and navigation services.

Core Care Model element 4 – support during care transitions – is important, and should take into consideration community services that should be maintained to assure that key supports are not lost during hospitalization or nursing stays. Page 9.

Thank you for your consideration.